Patient Consent Authorization

Family Photo/Media Release

Please review the following agreement before signing

Patient's Name:____

Address:____

Phone Number:____

I, ________________________, hereby grant the Hemophilia Outreach Center, **the right to use my/my child's/my ward's photograph for us in any media (including but not limited to, advertising material, website, video, social media outlets, Facebook, Twitter, Instagram, YouTube, television, radio, newspaper, magazine, brochures, pamphlets, newsletters, books, thank you letters, notecards, framed thank you photos or any other media** deemed appropriate by the Hemophilia Outreach Center.)(Strike any for exclusion) for any educational, promotional, informational and/or commercial purpose. I understand that the above information and material may be distributed in my own community and elsewhere.

I hereby release the Hemophilia Outreach Center, its Board, Director, employees, representatives, and any other parties so using the above described information and media from any and all claims, damages, liabilities, costs, and expenses which I now or hereinafter may have by reason of such use.

I further agree that all reproductions and all copyrights associated with the above described information and media are and shall remain the property of the Hemophilia Outreach Center, and its successors and/or assigns. I hereby agree not to request or accept any payment or other consideration in exchange for signing this release and for the use of any of the above information, materials, and/or media. I hereby agree that I/my child/my ward will be irrevocably bound by the terms of this release.

____ ________________________

Signature of Patient or Legal Representative/Relationship Date

____ ________________________

Witness Date

Hemophilia Outreach Center
2060 Bellevue Street
Green Bay, Wisconsin 54311
(920) 965-0606 1-800-992-0626